Patient ID _____

PARKWAY BACK CLINIC

BACK PAIN & SPINAL HEALTH CENTRE

CONFIDENTIAL PATIENT HEALTH RECORD

Name of Patient: _____

Date of Birth: _____

Chiropractor: _____

PATIENT TO COMPLETE PAGES 2-4

New Patient Appointment Date:	
Review of Findings Visit Date:	
Spinal Health Class Attended	**Yes** ❑ **No** ❑
Date MD Letter Sent:	
Date of Progress Exam:	
Date of Re-Assessment:	
6th Visit Questionnaire Complete	**Yes** ❑ **No** ❑
12th Visit Questionnaire Complete	**Yes** ❑ **No** ❑

Patient ID _____

PARKWAY BACK CLINIC: PATIENT HEALTH RECORD

Name of Chiropractor:		Date:
Mr/Mrs/Miss/Ms/Other:	First Name:	Surname:
Address: (in full)	Home Tel:	Sex: M/F
	Work Tel:	D.O.B.:
	Cell Phone:	Age:
	E-mail:	Height:
Postal Code:		Weight:
Marital Status:	Next of Kin:	Next of Kin Tel:
No. of children:	Ages of children:	
Occupation:	Years in Job:	Current Employer:
Previous occupation if less than 2 years:		
Who referred you to our clinic or how did you hear about us?		
Is there a specific person we may thank for referring you?		
Name of MD:		Insurance Company:
Address of MD:		Policy Number:

REASON FOR CONSULTING THIS CLINIC:	(please tick)
Symptomatic relief:	❑
Correction of the underlying cause of the problem:	❑
Achieve optimum health and well-being:	❑

PLEASE LIST:	
Your main health complaints:	
Any motor vehicle accidents:	
Any major falls or injuries:	
Any broken bones:	
Any medication currently being taken:	
Please list ALL surgeries and when:	
Have you had any X-rays?	YES ❑ NO ❑ If YES, of what and when?
Have you received any other medical treatment recently?	YES ❑ NO ❑ If YES, what and when?

SOCIAL HISTORY:			
Do you smoke?	YES ❑ NO ❑	packs per day:	number of years:
Do you drink alcohol? YE	YES ❑ NO ❑	units per week (beer, glass of wine, etc.):	
Do you drink caffeine drinks? (coffee, tea, cola, energy drinks)			YES ❑ NO ❑ cups per day:
How much water do you drink per day?			
Do you drink bottled and/or filtered water?			YES ❑ NO ❑
Do you currently take any supplements/vitamins/minerals?			YES ❑ NO ❑
If YES, please list which ones?			
How much regular exercise do you do?			
Do you play sports/have any hobbies?		YES ❑ NO ❑ please specify:	
How would you rate your health generally?			
I've never felt worse 1 2 3 4 5 6 7 8 9 10 I feel great			

WOMEN ONLY:	
Regular breast examination?	YES ❑ NO ❑
For X-ray purposes - Last menstrual period started:	
Is there any chance you may be pregnant?	YES ❑ NO ❑
Are you trying for a baby?	YES ❑ NO ❑
MEN ONLY:	
Regular testicular examination?	YES ❑ NO ❑
Have you had a prostate examination?	YES ❑ NO ❑ If YES, when was your last examination?

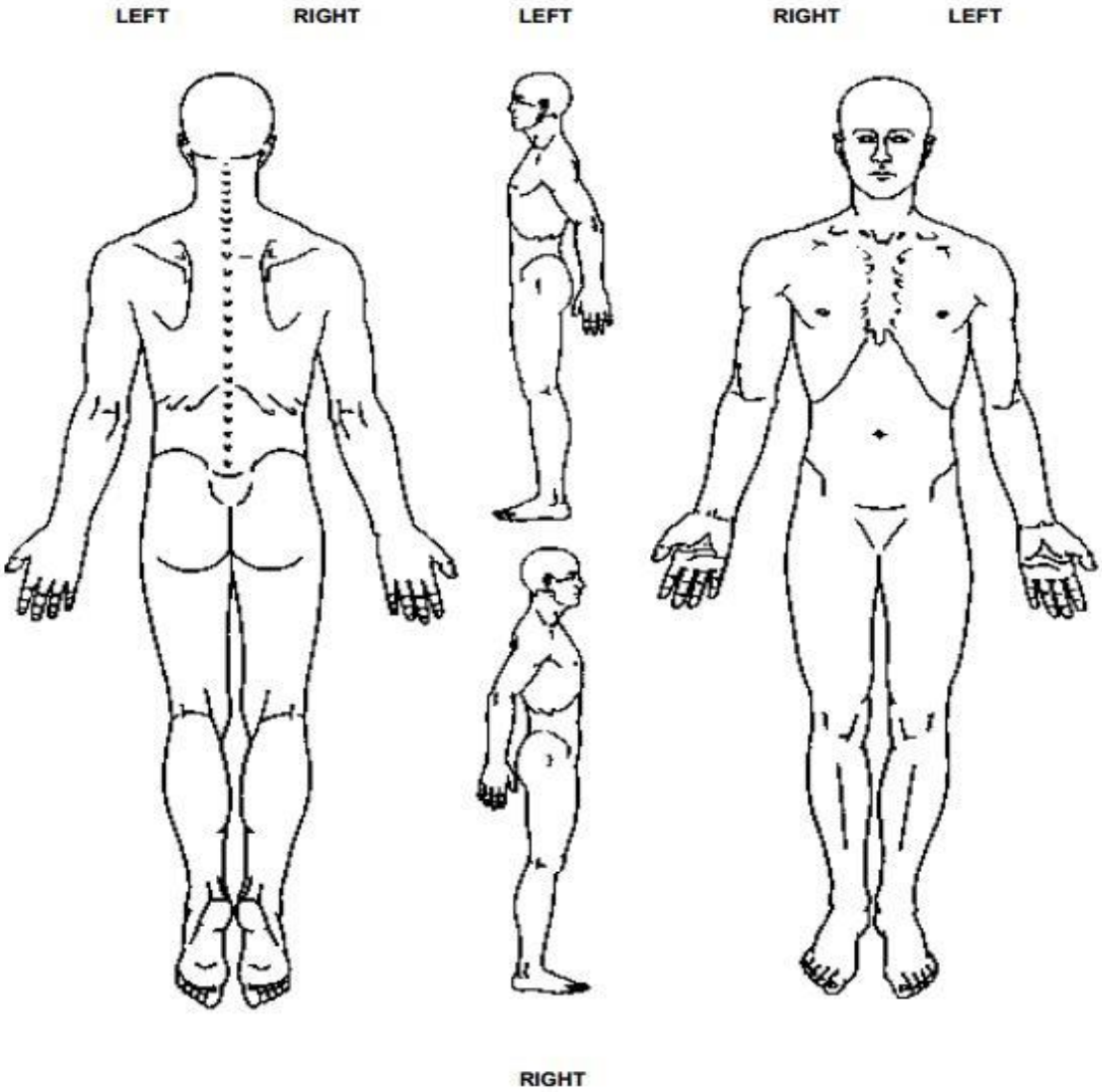
Patient ID _____

PAIN DIAGRAM

On the diagram below, please indicate where you are currently experiencing pain or other symptoms. Please number your *Primary (1)* and *Secondary (2)* complaints.

Key:

^^^ = Ache	. . . = Pins & Needles
xxx = Burning	\ \ \ = Stabbing
ooo = Numbness	*** = Other



Patient ID _____

PAIN SCALE

On a scale of 0 - 10 (with 0 being no pain, 10 being the worst pain),
please indicate below your pain level for your Primary complaint:

0 1 2 3 4 5 6 7 8 9 10

"0" at best "10" at worst

Please indicate below your level of pain for your Secondary complaint:

0 1 2 3 4 5 6 7 8 9 10

"0" at best "10" at worst

Have you, or any of your family members, suffered any of the following:
(Particularly siblings, parents, and grandparents)

	Self (please specify problem)	**Immediate Family** (please specify relative & problems)	**Year** (approx.)
Spinal problems:			
Liver/Kidney problems:			
Heart Disease/Stroke:			
Lung/Breathing problems:			
Digestion problems:			
Bowel problems:			
Bladder problems:			
Reproductive problems:			
Circulation problems:			
Diabetes:			
Cancer:			
Epilepsy/Nervous disorders:			
Allergy/Skin disorders:			
Blood Pressure problems:			
Migraine/Headaches:			
Dizziness:			
Tinnitus (buzzing in ears):			
Eyes/Ears/Nose/Throat problem			
Arthritis/Orthopedic problems:			
Multiple Sclerosis:			
Any other problems:			

Is there any other information you feel you need to discuss with your Chiropactor?

Please specify:

TODAY'S FEE SCHEDULE: Consultation/Examination: $____ (adult) $____ (child/student); X-rays (if necessary) $___ per set

CONSENT TO CONSULTATION AND EXAMINATION

I, _____ consent to a consultation and examination by a Doctor of Chiropractic at this Parkway Back Clinic. The information I provide will, to the best of my knowledge, be as accurate and truthful as possible. I also consent to my Chiropractor contacting my Medical Doctor with this information as needed. I understand that I am able to withdraw consent at any time if I feel at all uncomfortable with these procedures.

Signed: _____ Date: _____ Printed Name: _____

Patient ID _____

CASE HISTORY

Date _____

	Primary Complaint	Secondary Complaint
Complaint/Location:		
Differential Diagnoses:	DJD/DDD	DJD/DDD
	Sp/St	Sp/St
	Facet	Facet
	Disc	Disc
	Nerve Entrapment	Nerve Entrapment
	Fracture	Fracture
	Tumour	Tumour
	Infection	Infection
	AAA or VBAI	AAA or VBAI
	Other:	Other:
Dejerine's Triad:	YES ❑ NO ❑	YES ❑ NO ❑
Mechanism of Injury:		
Neurological Symptoms:		
Onset (Duration & Mode):		
Palliative:		
Provocative:		
Quality:		
Radiations/Referral:		
Severity:		
Time/Course/Frequency:		
Associated Symptoms:		
(Weight Loss/Night Pain)	YES ❑ NO ❑	
(Fever/Night Sweats)	YES ❑ NO ❑	
(Blood Loss)	YES ❑ NO ❑	
(Bowel/Bladder)	YES ❑ NO ❑	
Previous Treatment:		
& Outcome to Date		
ADL's/Sleep/Energy/Mood:	Increased ❑ Decreased ❑	
Other:		

EXAMINATION

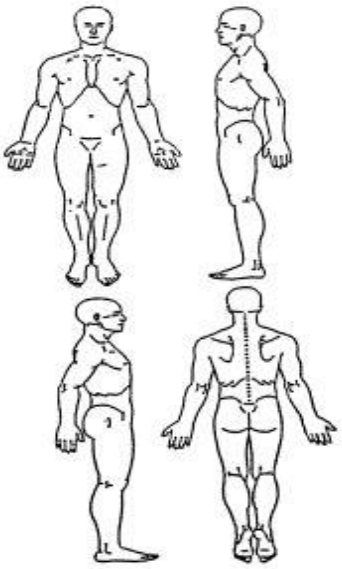
Vital Signs:

BP (140/90 - 90/60): _____ Pulse (60 - 100): _____

Resp (12 - 20): _____ Temp (95 - 99 F): _____

Patient ID _____

Postural Inspection:



Notes: _____

Palpation:

Left		Right
	Occ	
	C1	
	C2	
	C3	
	C4	
	C5	
	C6	
Rib	C7	Rib
	T1	
	T2	
	T3	
	T4	
	T5	
	T6	
	T7	
	T8	
	T9	
	T10	
	T11	
	T12	
	L1	
	L2	
	L3	
	L4	
	L5	
	S1	
	SIJs	

Other Chiropractic Tests:
(Inspection/Palpation/Percussion/Auscultation)

X = Joint Restriction/Malposition
O = Pain on Palpation

Range of Motion:

Cervical	Norm	Res.	Pain
FLEX	45		
EXT	45		
RR	80		
LR	80		
RLF	45		
LLF	45		

Lumbar/Thoracic:	Norm	Res.	Pain
FLEX	90		
EXT	30		
RR	30		
LR	30		
RLF	30		
LLF	30		

Notes:

Shoulder:	Norm	R	L	Pain
FLEX				
ABD				
ER				
ABD & ER				
IR				

Elbow:	Norm	R	L	Pain
FLEX	150			
EXT	0			
PRO	80			
SUP	80			

Wrist:	Norm	R	L	Pain
FLEX	60			
EXT	70			
RD	20			
UD	30			

Hip:	Norm	R	L	Pain
FLEX				
EXT				
ABD				
ADD				
IR				
ER				

Knee:	Norm	R	L	Pain
FLEX	150			
EXT	10			
IR	15			
ER	20			

Ankle:	Norm	R	L	Pain
DFLEX	20			
PFLEX	40			
INV	20			
EV	30			

Patient ID _____

ORTHOPEDIC EXAMINATION

Cervicothoracic	L	R
Valsalva		
VBAI Test(s)		
Compression		
Distraction		
Shoulder Depression		
Soto-Hall		
Bakody/Reverse		
Adsons/Reverse		
Halstead/BrachPlexus		
Wrights		
Edens		
Sheppelmans		
Rib Expansion		
Adams		
Spinous Percussion		
Kernigs/Brudzinskis		
Other		

Lumbopelvic	L	R
Valsalva		
AAA Test(s)		
Minors Sign		
Kemps		
Bechterews		
SLR –active/passive		
Braggards/Sicards		
Turyns		
WLR		
Double Leg Raise		
Bonnets		
Piriformis Stretch		
Nachlas/Elys		
Hibbs		
Yeomans		
Short Leg		
Other		

Shoulder	L	R
G/H Apprehension		
Sulcus Sign		
Impingement Test		
Dawburns Push Butt		
Full Can/Empty Can		
Speeds/SLAP		
Yergasons		
Jobes/Hawkins		
O'Briens		
A/C Differential		
Gerbers Lift Off Test		
DIT/Crank		
AP/PA Pressure		
Other		

Hip/Knee	L	R
Fabere/Patrick		
Leg Length		
Allis/Galleazzis		
Thomas		
Obers		
Ant/Post Drawer		
Lachmans		
Varus/Valgus		
McMurrays		
Applys Comp/Distract		
Patellar Grind		
Waldrons		
Medial Plica Test		
Other		

Elbow/Wrist/Hand	L	R
Varus/Valgus		
Valgus Ext Overload		
Cozens/Mills		
Middle Finger Ext		
Golfers Elbow Test		
Middle Finger Flex		
Phalens/Prayer		
Tinnel Tap(s)		
Other		

Leg/Ankle/Foot	L	R
Thompsons/Achilles		
Homans/Moses		
Tarsal Tunnel Tap		
Ant/Post Drawer		
Varus/Valgus		
Mortons		
Other		

Patient ID _____

ORTHOPEDIC EXAMINATION

Reflexes	L	R
C5 Biceps		
C6 Brachioradialis		
C7 Triceps		
L4 Patellar		
L5 Medial Hamstring		
S1 Achilles/Lat Ham		
T7-T12 Abdominal		
Dermatomes	L	R
C5		
C6		
C7		
C8		
T1		
L1		
L2		
L3		
L4		
L5		
S1		
Other		

Myotomes	L	R
Upper Extremity		
C5 Deltoid		
C6 Wrist Extensors		
C7 Wrist Flexors		
C8 Finger Flexors		
T1 Finger Interossei		
Lower Extremity	L	R
L1-2 Hip Flexors		
L3 Hip Adductors		
L4 Tibialis Anterior		
L5 Ext Digitorum/Hall		
S1 Peroneii		
Heel Walk L4-5		
Toe Walk S1-2		
Vibration		
Babinski Reflex		
Stereo/Graphesthesia		
Rhombergs		
Dysmetria		
Dysdiadokinesia		

Cranial Nerve	Positive Findings	Cranial Nerve	Positive Findings
I (smell)		VII (hearing/balance)	
II/III (pupils/acuity/fundus)		IX/X (taste/gag/voice/swallow)	
III/IV/VI (eye movements)		XI (SCM/upper trapezius)	
V (sensory/bite/jaw reflex)		XII (tongue muscle)	
VII (taste/facial expression)		Other	

CONSENT TO X-RAY EXAMINATION

I confirm my agreement to having an X-ray examination for the purpose of assisting my Doctor of Chiropractic in his/her diagnosis of my condition.

(For women only)
I confirm that I am not pregnant and I am not currently trying to get pregnant. I have had the risks of X-ray radiation in pregnancy explained to me.

I have had the reason explained to me why an X-ray examination is necessary for my treatment and I hereby give my consent to being exposed to X-rays, as requested below:

Signed: _____ Date: _____

X-Ray Examination Criteria				**Views Required**	
Age 50 or over	❑	Pyrexia	❑	AP Cx:APOM:Lat Cx	AP Ax:Lat Ax: Obl Ax
Trauma	❑	Investigation of scoliosis	❑	Obl Cx:Flex/Ext Cx	AP Fx:Lat Fx: Obl Fx
Neurological deficit	❑	Surgery in region of interest	❑	APTx:LatTx:Swimmer	APIR/ERShx:AC Spot
Unexplained weight loss	❑	Failed to improve with conservative care	❑	APLx:LatLx	AP Ex:Lat Ex:Obl Ex
Drug or Alcohol abuse	❑	Equivocal biomechanical findings	❑	OblLx:AP/Lat L5 Spot	PA Wx:LatWx:OblWx
Inflammatory arthropathy	❑	Investigation of extreme postural anomaly	❑	AP Px:AP/LatSx/Ccx	PA Hd:LatHd:Obl Hd
Malignancy	❑	Clinical exam limited by pain	❑	AP Hx:Frogleg Hx	PA Tb:Lat Tb:Obl Tb
History of steroids	❑	Other _____	❑	AP Kx:LatKx:OblKx Tunnel Kx:Sunrise Kx	Other _____

RADIOLOGICAL EXAMINATION **X-Ray Date:** **X-Rays Taken At:**

Results: (**A**lignment)

(**B**one)

(**C**artilage)

(**S**oft Tissue)

X-Ray Conclusions/Recommendations:

CASE SUMMARY

Patient Name: D.O.B.:

Presenting Complaints:

Key Examination Findings/Relevant Imaging/External Studies:

(Normals)

(Abnormals)

Contraindications/Red Flags:

Yellow Flags/Complicating Factors:

Working Diagnoses:

1

2

3

Differential Diagnoses:

1

2

3

Prognosis for Primary Presenting Complaint:

Referral Poor Fair Good Very Good Excellent

TREATMENT PLAN:

S: (ROF)	**D** = Diversified	**Result:**
	T = Thompson	✔ = good cavitation
O: $_{L}SI_{R}$ $_{L}L5_{R}$ $_{L}L3_{R}$ $_{L}L1_{R}$ $_{L}T12_{R}$ $_{L}T10_{R}$ $_{L}T8_{R}$ $_{L}T6_{R}$ $_{L}T4_{R}$ $_{L}T2_{R}$ $_{L}T1_{R}$ $_{L}C7_{R}$ $_{L}C5_{R}$ $_{L}C3_{R}$ $_{L}C1_{R}$ $_{L}C0_{R}$ Other	**A** = Activator	/ = okay movement
	C = Cox	× = hard to adjust

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment. The risks include:

* **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

* **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

* **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

* **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

* **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

* **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____

Name (Please Print)

_____ Date: _____ 20____

Signature of patient (or legal guardian)

_____ Date: _____20____

Signature of Chiropractor